Health and Social Care
Ombudsman Body

SUMMARY REPORT

Case Reference Number: HSCOB/2023/124

Regulation 24(6) of the Complaints Regulations 2022 requires the HSCOB to publish reports of its reviews and investigations on its website. Regulation 24(7) also requires the Body to give due regard to data protection legislation and the general duty of care and confidence.

Reports are therefore presented in a format that summarises the nature of the complaint together with the relevant key findings, conclusions and recommendations. They do not however contain any personally identifiable data or information.

Complainants receive a copy of the original unredcated report prior to their publication in a summary format. Reports intended for publication must be posted on the HSCOB website within one month of the unredacted original version being sent to the complainant.

Summary reports are intended to inform the public about the work of the HSCOB and raise awareness of the Body's role in contributing to the transformation and improvement of health and care services on the Isle of Man.

N.B HSCOB acknowledged to the complainant and Manx Care that the NHS (Complaints) Regulations 2022 were not in place at the time of this complaint. Recommendations made to Manx Care by HSCOB were made in line with the aforementioned Regulations to assist Manx Care in adjusting to them going forward. It is also noted that much of what is contained within the 2022 Regulations was also consistent with established good practice in complaints handling.

Manx Care Service(s) Complained About

Ophthalmology Out Patients Dept/Noble's Hospital

The Complaints

Delay to treatment due to multiple cancellation of outpatient appointments to monitor an existing eye condition

The Complainant's Desired Outcomes

Explanation of the management of repeated cancelled out patient appointments, specifically how the risk to the patient is assessed and what the system is for prioritising patients for rebooked appointments where this is indicated.

Explanation of the system for recording telephone calls from patients "chasing" a new appointment following a cancellation, and how concerns being raised by such patients are brought to the attention of management and clinicians.

Review Findings & Conclusions

The Review undertaken by HSCOB established the following findings:

Letter of acknowledgment of complaint from Manx Care is a standard template letter. It includes the option "to meet with us", but does not stipulate that the meeting is to discuss the complaint nor does it include a summary of the complaint. (NHS (Complaints) Regulations 2022 Part 2 10 (8) (a). (Reg 10 (5).)

Complaint letter and questions were forwarded by the Patient Care Quality and Safety Team (PCQS) to the Ophthalmology consultant and secretary. The only response, from the secretary, is a list of the appointments made and reason for cancellations. Although questions were put to the consultant Ophthalmologist by email there is no record of a response to the questions being received, or attempts to obtain a response by PCQS.

No evidence of a record by Manx Care of complainant's attempts to re-schedule cancelled appointments in line with the frequency of monitoring advised by the consultant Ophthalmologist or concerns being brought to the attention of those managing the waiting list and the clinicians who had oversight of care.

First response to complaint dated 18 January 2022 and signed by the Matron, Surgery, Surgical Services identified complaint as "lack of follow up appointments" following treatment received in UK prior to returning to IOM. There is no reference in the letter to complaint of "treatment delay" or its consequences. The letter provides a detailed account of the follow up appointments made, reasons for cancellation and the outcome of those appointments which did take place. The letter makes no reference to the questions submitted with the complaint, nor does it provide any information by way of answering the questions.

An apology is made for the fact that complainant "did not receive your ophthalmology appointments as you would normally have done under ideal circumstances".

Having expressed dissatisfaction with the response, reiterating the events leading to the complaint and asking for answers to a total of now eight questions Manx Care advised that further investigation was being undertaken into the additional questions, and a meeting was

offered with the PCQS team to discuss the complaint. A meeting was accepted, subject to the further investigation and provision of answers as requested.

in a further letter from the CEO, Manx Care did not correctly identify the nature of the complaint. It addressed some but not all the questions asked. It referred to an investigation having been completed. When asked for a copy of this investigation report, Manx Care advised that the CEO's letter was the investigation report. There was no invitation to meet to discuss the response; on the contrary the letter states, incorrectly, that a meeting had been declined.

Neither a separate investigation report nor the terms of reference for the investigation could be found in the Complaint file provided by Manx Care.

Written responses subsequent to the acknowledgement of the complaint provided by Manx Care would not have been compliant with the NHS (Complaints) Regulations 2022 Part 2 11 (3) (a) –
(c), which require specifically that such responses

- Summarise the nature and substance of the complaints
- Confirms whether the complaint in full or in part is upheld
- Describes the investigation

The only " action" referred to in the final response (Reg 11 (3) (d) (ii)) describes Manx Care's strategy to address waiting lists for those requiring cataract surgery. The complainant was not on the waiting list for cataract surgery.

Review Outcome

Complaint upheld in relation to:

Failure by Manx Care to adhere to the Complaints Regulations;

Failure to follow up cancelled appointments.

Complaint not upheld:

That above failures caused or contributed to the deterioration in condition, due to a lack of medical evidence on this point.

Review Recommendations

The following recommendations have been made to Manx Care:

Review the policy and procedure for managing cancelled out patient appointments to ensure these include the prioritising and recording of re-scheduled appointments involving the clinician responsible for the patient. Should such a policy /procedure not be in place these

should be developed as a matter of urgency, implemented, and published. The procedures should be subject to regular audit.

Review the procedure for the management of telephone contacts to Patients Services, including how these are recorded and actioned, and the system in place for escalating problems to senior managers and clinicians. If not in place, written procedures should be drafted, staff trained to apply them, and the procedures implemented.

Manx Care issue an adequate, genuine apology to the complainant that addresses the true nature of the complaint raised.

Investigations by Manx Care under Part 2 of the Regulations to be independent of the service area complained about, and should include terms of reference after having confirmed with the complainant the nature and substance of the complaint. In accordance with the Regs, complainants must be invited to meet to discuss their complaint when it is first received (Part 2 Section 10 (5), and thereafter as part of the investigation (Section 11 (2).

All communications from PCQS team must comply with the Regulations.